Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
TEXAS BONE AND JOINT CENTER

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-17-1710-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
FEBRUARY 6, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Texas Mutual has recently paid considerable lower for a pharmaceutical drug that what is normally paid for by other health plans. Please find enclosed a copy from the Redbook, the most recent Average Wholesale Price (AWP) information regarding this drug. The AWP is a commonly utilized standard to determine the reimbursement of these types of claims…Medicare guidelines are 125% of the AWP. The fair and reasonable reimbursement for the Interarticular Joint Kit is $675.00."

Amount in Dispute: $1,600.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requester billed $1,600.00 for an injection kit, coded with J3490. Texas Mutual paid $6.74." The requestor argues in its DWC packet that per Rule 134.1 reimbursement is to be fair and reasonable. The requestor seems to be demonstrating that a rate built on Redbook's average wholesale price (AWP) for J3490 is the first step to fair and reasonable pricing. Apparently Redbook's AWP for the injection kit in question is $540.00. The second step in the requestor's methodology is a payment adjustment factor of 125% applied to the AWP for a total of $675.00. The key question here is does this method meet the requirements of 134.1(f)(1) and (3)? No. 1. Effective medical cost control is not achieved because the AWP is determined by the manufacturers. Those manufacturers can change their pricing for any reason. There is nothing wrong in doing so. The problem is that such a method does not lead to effective medical cost control and is not then fair and reasonable. 2. Texas Mutual paid the MAR for the injection code billed. The requestor's DWC60 packet indicated Lidocaine and Kealog-40, a steroid, were used with the injection. Texas Mutual paid $6.74 for the steroid based on the October ASP Pricing File, which is the Payment Allowance Limits for Medicare Part B Drugs."

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 17, 2016	HCPCS Code J3490	$1,600.00	$0.00
	CPT Code 27096-LT	$0.00	$0.00
TOTAL		$1,600.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - CAC16-Claim/service lacks information which is needed for adjudication.
   - CACP12-Workers' compensation jurisdictional fee schedule adjustment.
   - CAC-P5-Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement.
   - 217-The value of this procedure is included in the value of another procedure performed on this date.
   - 225-The submitted documentation does not support the service being billed we will re-evaluate this upon receipt of clarifying information.
   - 892-Denied in accordance with DWC rules and/or medical fee guideline including current CPT code descriptions/instructions.
   - 18, 224-Duplicate charge.

Issues

Is the requestor entitled to additional reimbursement for HCPCS code J3490?

Findings

On the disputed date of service, the requestor billed CPT codes 27096-LT and J3490 for a left sided S1 injection. The respondent paid 27096-LT and is not in dispute. The respondent paid $6.74 for HCPCS code J3490 based upon reason codes "CACP12-Workers' compensation jurisdictional fee schedule adjustment," and "CAC-P5-Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement."

28 Texas Administrative Code §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

HCPCS code J3490 is defined as "Unclassified drugs."

Per 2016 NCCI Policy Manual for Medicare Services, Chapter 12, (A) "The HCPCS Level II codes are alpha-numeric codes developed by the Centers for Medicare and Medicaid Services (CMS) as a complementary coding system to the *CPT Manual*. These codes describe physician and non-physician services not included in the *CPT Manual*, supplies, drugs, durable medical equipment, ambulance services, etc." HCPCS code J3490 is a HCPCS Level II code. Therefore, the guidelines outlined in 28 Texas Administrative Code §134.203(d)(1-3) apply to the disputed service.

28 Texas Administrative Code §134.203(d)(1-3) states "The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows:

(1) "125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule."

HCPCS code J3490 does not have a fee listed in DMEPOS fee schedule for Texas.

(2) "if the code has no published Medicare rate, 125 percent of the published Texas Medicaid fee schedule, durable medical equipment (DME)/medical supplies, for HCPCS."

HCPCS code J3490 has a fee of $5.01 listed in Texas Medicaid fee schedule; therefore, the MAR is $5.01 X 125% = $6.26. The respondent paid $6.74. As a result, additional reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		3/29/2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.